

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445183	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 08/13/2018
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 438 NORTH WATER AVE GALLATIN, TN 37066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey follow up was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 08/13/2018 for all previously cited deficiencies on 6/18/2018. During this Life Safety Survey, Gallatin Health Care Center, LLC was found in substantial compliance with the requirements of the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-6 Standards for Nursing Homes and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).</p>	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION POC #1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445183	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2018
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE CENTER, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 438 NORTH WATER AVE GALLATIN, TN 37066	
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K 321 SS=0	<p>Hazardous Areas - Enclosure CFR(s): NFPA 101</p> <p>Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS 19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the hazardous areas.</p> <p>The findings include:</p> <p>1. Observation on 06/18/2018 at 11:04 AM,</p>	K 321	<p>A self-closing apparatus was installed on the medical records room door 6/20/18. The maintenance shop doors have been replaced with fire rated doors which also corrected the 3/4 inch under cut. A self-closing apparatus has been installed on the door to room 202.</p> <p>All rooms designated as storage were checked for self-closing doors and actions taken as needed.</p> <p>Maintenance staff will add auditing of self-closing doors to monthly preventative maintenance checklist.</p> <p>Maintenance Director will report results to QAC monthly for three months or until QAC deems compliance.</p>	7/20/18

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TITLE

(X6) DATE

Paul Z. Cottrell

Administrator

7/12/18

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		445183		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		06/18/2018	
NAME OF PROVIDER OR SUPPLIER GALLATIN HEALTH CARE CENTER, LLC							
	INDICATORY	MUST BE PRECEDED BY IDENTIFYING INFORMATION	ID PREFIX TAG	EACH CO OSS-REF	SHOULD BE APPROPRIATE		
K 321	Continued From page 1 revealed the medical records room door was not self-closing within the frame. NFPA 101, 8.3.3.1 (2012 Edition), NFPA 80, 7.1.4 (2010 Edition), NFPA 80 6.1.4.2 (2010 Edition) 2. Observation on 6/18/2018 at 12:09 PM, revealed the maintenance shop doors (2 of 2) were not rated, NFPA 101, 19.3.2 (2012 Edition) 3. Observation on 6/18/2018 at 12:10 PM, revealed the maintenance shop doors were under cut over 3/4 of an inch, NFPA 101, 19.3.2 (2012 Edition) NFPA 80, 4.8.4.1 (2010 Edition) 4. Observation on 6/18/2018 at 12:20 PM, revealed 202 in Memory Care had been changed to storage and was not self-closing in the frame. NFPA 101, 19.3.2 (2012 Edition) Maintenance staff was present for the findings which were later acknowledged by the administrator during the exit conference on 06/18/2018.		K 321				
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations and document review,		K 345	The duct detectors were inspected and confirmed operational on 6/20/18 by contractor Pye Barker. All other duct detectors were inspected and confirmed operational. Continued on next page.		7/20/18	

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K 345	Continued From page 2 the facility failed to maintain the fire alarm system. The findings include: Document review on 06/18/2018 between 9.30 AM and 11.00 AM, revealed duct detectors that had not been inspected during the annual fire alarm inspection conducted on 05/16/2018. NFPA 101, 19.3.2.5.3(11) (2012 Edition), NFPA 72, 14.2.1.2.2 (2010 Edition) Maintenance staff was present for the findings which were later acknowledged by the administrator during the exit conference on 06/18/2018.	K 345	K345 continued. Maintenance Director will review next duct inspection report to verify that all duct detectors were inspected and confirmed operational. Maintenance Director will present duct inspection reports to Administrator who will report results to QAC.		
K 351 SS-D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	K 351	The shelving units were modified in the closets of rooms 213 and 214 to provide appropriate spacing for fire sprinklers. The sprinkler in the closet of room 423 was re-located more than 4 inches from the wall. Guards were installed on the sprinklers in the walk in freezer and walk in cooler. All sprinkler heads have the potential to be affected by this practice. All sprinkler heads were inspected and action taken as needed. Continued on next page.	7/20/18	

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K 351	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations and document review, the facility failed to properly install the sprinkler system. The findings include: 1. Observations on 06/18/2018 at 12:37 PM, revealed fire sprinklers in the closets of room 213 and 214 are obstructed by the shelving units. NFPA 101, 19.3.5.1 (2000 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 6.5.5 (2010 Edition) 2. Observations on 06/18/2018 at 12:37 PM, revealed a sprinkler installed less than 4 inches from the wall in the closet of patient room 423. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 8.7.3.3.1 (2010 Edition) 3. Observations on 6/18/2018 at 12:46 PM, revealed the sprinklers in the walk in freezer and walk in cooler were not guarded against physical damage. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 6.2.8 (2010 Edition) Maintenance staff was present for the findings which were later acknowledged by the administrator during the exit conference on 06/18/2018.	K 351	K351 continued. Monthly Sprinkler head inspection has been added to the preventive maintenance schedule. Maintenance Director will verify completion of sprinkler head monthly inspection and report results to QAC monthly until QAC deems compliance.		
K 353 SS-D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are	K 353	The sprinkler inspection report from 3 rd quarter 2017 was discovered missing in Nov. 2017. Sprinkler inspection records are now current. The 2 corroded sprinklers underneath the station 1 patio were replaced 7/12/18. Con't next page	7/20/18	

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K 353	<p>Continued From page 4</p> <p>inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and document review, the facility failed to maintain the fire sprinkler system.</p> <p>The findings include:</p> <p>1. Document review on 06/18/2018 between 9:30 AM and 11:00 AM, revealed no documentation for the third quarter sprinkler inspection for 2017. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 24.6.1 (2010 Edition), NFPA 25, 5.1.1.2 (2011 Edition)</p> <p>2. Observations on 6/18/2018 at 12:04 PM, revealed 2 of 9 sprinklers corroded underneath the station 1 patio. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.1.1 (2012 Edition), NFPA 13, 26.1 (2010 Edition), NFPA 25, 5.1.1.2 (2011 Edition) NFPA 25, 5.1.1.4 (2011 Edition)</p>	K 353	<p>K 353 continued.</p> <p>The 9 sprinklers with grease build up in the kitchen were replaced 6/26/18.</p> <p>All sprinkler heads have the potential to be affected by this practice.</p> <p>All sprinkler heads were inspected and action taken as needed.</p> <p>Monthly Sprinkler head inspection has been added to the preventive maintenance schedule.</p> <p>Maintenance Director will verify completion of sprinkler head monthly inspection and report results to QAC monthly until QAC deems compliance.</p>		

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K 353	Continued From page 5 3. Observations on 6/18/2018 at 12:04 PM, revealed 9 of 9 loaded with grease build up in the kitchen. NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101.9.7.1.1 (2012 Edition), NFPA 13, 26.1 (2010 Edition), NFPA 25, 5.1.1.2 (2011 Edition) NFPA 25, 5.1.1.4 (2011 Edition) Maintenance staff was present for the findings which were later acknowledged by the administrator during the exit conference on 06/18/2018.	K 353			
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to maintain clearance around electrical panels. The findings include: 1. Observations on 06/18/2018 at 1:10 PM, revealed electrical panels obstructed by carts and boxes in the following locations: a. employee break room b. laundry service corridor. NFPA 101, 19.5.1.1	K 511	The obstructions to the electrical panels in the employee break room and laundry service corridor have been removed. All electrical panels have the potential to be affected by this practice and were inspected for obstructions and action taken as needed. Staff were in-serviced re: not obstructing electrical panels and signage posted. Inspection of electrical panels was added to the maintenance daily checklist. Maintenance Director will randomly audit the electrical panels weekly and report results to the QAC monthly for three months or until the QAC deems compliance.	7/20/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2018
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K 511	Continued From page 6 (2012 Edition) NFPA 101, 9.1.2 (2012 Edition) NFPA 70, 110.26 (2011 Edition) Maintenance staff was present for the findings which were later acknowledged by the administrator during the exit conference on 06/18/2018.	K 511			
K 741 SS=ID	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced	K 741	The 2a-400 court yard was labeled as a non-smoking area. Other non-designated smoking areas were inspected for evidence of smoking. Staff were in-serviced on designated smoking area. Maintenance staff will add inspection of non-designated smoking areas to daily checklist. Maintenance Director will audit daily checklist and report results to the QAC monthly or until QAC deems compliance.		7/20/18

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K 741	Continued From page 7 by: Based on observations the facility failed to maintain the smoking areas. The finding included: Observations on 6/18/2018 at 12:09 PM, revealed cigarette filters in trash bags in the 2A-400 court yard. Maintenance staff was present when this deficiency was identified and it was later acknowledged by administration in the exit conference on 6/18/2018.	K 741		
K 923 35-D	Gas Equipment - Cylinder and Container Storage CFR(s) NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be	K 923	The oxygen bottles were removed from room 328 and oxygen in use signs installed. All resident rooms were inspected for properly stored oxygen containers/labeling and action taken as needed. Nursing staff were in-serviced on proper oxygen storage and labeling of room. Nurse managers will audit resident rooms daily for three weeks, weekly for three weeks then monthly for three months and report results to DON. The DON will report audit results to monthly QAC until QAC deems compliance.	7/20/18

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K 923	<p>Continued From page 6</p> <p>handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION. OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and document review, the facility failed to properly store portable oxygen bottles.</p> <p>The findings include:</p> <p>1. Observation on 06/18/2018 at 12:13 PM, revealed oxygen bottles not properly secured in room 328. NFPA 99 11.3.2.1 (2012 Edition)</p> <p>2. Observation on 06/18/2018 at 12:13 PM, revealed room 328 is not properly labeled to contain oxygen storage within the room. NFPA 55, 4.10.2.3 (2010 Edition)</p> <p>Maintenance staff was present for the findings which were later acknowledged by the administrator during the exit conference on 06/18/2018.</p>	K 923			

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{E 000}	Initial Comments During the Emergency Preparedness Survey completed on 06/18/2018, this facility was found to be in compliance with all Emergency Preparedness requirements.	{E 000}			

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